STATE OF NORTH DAKOTA

BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF:	)	
	)	
North Dakota State Board of Medical Examiners-Investigative Panel B,	)	**RECOMMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER**
Complainant,	)	
vs.	)	
	)	
George S. Hsu, M.D.	)	OAH File No. 20040095
	)	
Respondent.	)	

. . . . . .

On March 22, 2004, the Board of Medical Examiners ("Board") requested the designation of an administrative law judge ("ALJ") from the Office of Administrative Hearings to conduct a hearing and to issue recommended findings of fact and conclusions of law, as well as a recommended order, in regard to the matter of George S. Hsu, M.D. ("Dr. Hsu"). With the request, the Board sent an Ex Parte Order of Temporary Suspension issued by the Board to Dr. Hsu on March 19, 2004. Under N.D.C.C. § 43-17-32.1, the order immediately suspended the license to practice medicine in North Dakota of Dr. Hsu. Included with the order were a Complaint, Verified Affidavit of Craig J. Lambrecht, M.D., a Notice of Hearing, and a statement of Witness List and Exhibits. The notice scheduled a hearing for March 26, 2004. On March 22, 2004, the undersigned ALJ was designated to preside as hearing officer.

The Complaint cites as grounds for administrative action allegations of violations of N.D.C.C. § 43-17-31, specifically alleging that Dr. Hsu has engaged in a continued pattern of inappropriate care within the meaning of N.D.C.C. § 43-17-31(21), in regard to three specific

patients, his practice of medicine constituting significant risk of serious and ongoing harm to the public, requiring immediate suspension of Dr. Hsu's license to practice medicine in North Dakota.

On March 23, 2004, at the request of counsel for Dr. Hsu, Mr. Michael C. Waller, Bismarck, the hearing officer issued an Order Granting Continuance and Notice of Prehearing Conference. A prehearing conference was held on March 30, 2004. On April 6, 2004, the hearing officer issued a Notice of Hearing and Protective Order. The notice rescheduled a June 15 and 16, 2004, hearing. The protective order ordered certain measures to protect the confidentiality of patients and patient records. *See* below. On June 10, 2004, at the request of the parties, the hearing officer issued a Notice of Rescheduled Hearing. This notice rescheduled the hearing for August 17 and 18, 2004.

The hearing was held as rescheduled on August 17 and 18, in the Office of Administrative Hearings, Bismarck, North Dakota. Investigative Panel B ("Panel B") was represented by Mr. John M. Olson, special assistant attorney general. Dr. Hsu was present at the hearing. He was represented at the hearing by Mr. Waller and Mr. William A. Strutz, Bismarck. Panel B called seven witnesses to testify, Dr. Hsu, Dr. Craig J. Lambrecht, Dr. Chuck Dahl, Dr. Samir Turk, Dr. Kevin Koester, Dr. Thomas Matheson, and Mr. Kurt Waldbillig (*see* exhibits 4-8, respectively, for *curriculum vitae* of Drs. Lambrecht, Dahl, Matheson, Koester, and Turk). Investigative Panel B provided a list of all of the exhibits it offered that is in a black binder with Panel B's exhibits. Mr. Waller presented Dr. Hsu's case. Dr. Hsu testified in his own behalf and called as additional witnesses Dr. Troy Pierce, Dr. Herbert J. Wilson, and Dr. Ben W. Muscha. (*See* exhibits D-G, respectively, for *curriculum vitae* of Drs. Hsu, Pierce, Muscha, and Wilson.) Panel B offered 10 exhibits (1-10), all of which were admitted (the

hearing officer took official notice of exhibit 2, the record from the other current administrative action against Dr. Hsu). Exhibit one contains separate sections on Patients 1-3. Dr. Hsu offered 10 exhibits (exhibits D-M), all of which were admitted. *See* attached exhibit list. The ALJ has prepared a separate, partial exhibit list which includes all of the exhibits offered by Dr. Hsu. All of the protected exhibits in either list are so noted and they are separately sealed.

On August 20, 2004, after the close of the hearing, pursuant to telephone conference between counsel and the hearing officer on August 19, 2004, the hearing officer issued a Notice of Hearing for Oral Argument. Oral argument was heard from counsel on September 2, 2004, at which time the hearing on this matter was closed.

The evidence presented in this matter contains documentary evidence protected as to confidentiality pursuant to the April 6, 2004, protective order. *See* attached exhibit lists. Those documents so protected are noted on the exhibit list and sealed subject to review only by counsel for the parties, the parties (Dr. Hsu and Panel B), and the Board in its deliberations on this matter, as well as any court upon review in an appeal on this matter. Further, during the course of the hearing, several times, portions of the hearing were held pursuant to the protective order to protect confidentiality of peer review documents. *See* N.D.C.C. § 23-34-03. Those portions of the tape containing confidential portions of the hearing, if transcribed, must be transcribed and segregated from the remainder of the transcript, and then sealed subject to review only by counsel for the parties, the parties and the Board, as well as any court upon review in an appeal on this matter. If not apparent from reviewing the tapes themselves, the hearing officer must be consulted in regard to segregation and sealing of confidential portions of the transcript.

In the Complaint and at the hearing, Panel B noted the current administrative disciplinary action pending before the Board against Dr. Hsu and asked that the hearing officer take official

notice of that action and incorporate into this administrative disciplinary action the results of that pending action. The hearing officer takes official notice of the November 26, 2004, Recommended Findings of Fact, Conclusions of Law and Order, as well as the proposed final Order ("First Decision"), issued by him in the pending administrative disciplinary action against Dr. Hsu before the Board. However, the allegations of that matter stand proven as stated in that First Decision and are not factually related to the allegations of this matter. Thus, for this matter, the recommended findings of fact, conclusions of law, and order, and the proposed final order ("Second Decision") will be substantially different than the findings of fact, conclusions of law, and order of the First Decision. Yet, because no disciplinary action was taken by the Board in regard to the First Decision, the hearing officer has incorporated the findings and conclusions made in the First Decision into the Second Decision for purposes of recommending to the Board the proposed final Order imposing discipline on Dr. Hsu. In other words, the disciplinary action recommended by the hearing officer in this matter is cumulative, and will include, if appropriate, discipline recommended from the First Decision along with additional discipline recommended from the Second Decision. The cumulative effect of the two could be the same or greater discipline as that recommended in the First Decision.

Finally, on July 1, 2004, the ALJ wrote to counsel informing them (copying Mr. Sletten) that he was receiving numerous letters from members of the community of Elgin. He continued to receive letters, thereafter. All letters received to date are enclosed with the record. He advised counsel that he was not reading those letters because they appear not to be relevant to the issues for hearing. He has not read the letters. The ALJ advises that the Board also not read the letters for the same reason. However, it should be noted that the fact that so many letters are being written and received, along with the attendance at the hearing of many members of the

community of Elgin, appears to show broad support for Dr. Hsu, although to what extent that support may be affected by a showing of a continuing pattern of inappropriate care is uncertain. Certainly, however, the Board could take notice that the community has demonstrated an interest in continuing to have a doctor available to them in Elgin.

Based on the evidence presented at the hearing and the oral argument of the parties, the administrative law judge makes the following recommended findings of fact and conclusions of law.

Following the first three findings of fact, the findings of fact will be divided in three parts relating to the care for the three patients at issue in this matter, FOF #s 4-6. These three findings of fact contain numerous subparts.

FINDINGS OF FACT

1. Dr. Hsu is a physician currently licensed to practice medicine in North Dakota under the provisions of N.D.C.C. ch. 43-17. Dr. Hsu was first licensed by the Board to practice medicine in North Dakota in 1985. Exhibit 1. He has been continuously licensed to practice since that time, until his license was suspended by ex parte order of the Board issued on March 19, 2004.

2. Dr. Hsu has been in the private practice of medicine since 1987 in Elgin and Glen Ullin, North Dakota. He has hospital privileges at Jacobson Memorial Hospital in Elgin ("the Hospital"). *See* exhibit D, *Curriculum Vitae* of Dr. Hsu.

3. From July 2001 through June 2003, Dr. Hsu provided inappropriate or substandard medical care as a physician to seven patients, O.M., B.H., E.B., K.K., G.H., M.M., and L.M. Official Notice. *See* First Decision for more specific findings, conclusions and analysis. The care provided by Dr. Hsu in regard to these seven patients took place on or about July 2001,

August 2001, August 2001, February 2003, March 2003, April 2003, and June 2003, respectively. The Board issued its Ex Parte Order of Temporary Suspension against Dr. Hsu on March 19, 2004, after investigating allegations with regard to care provided by him to three patients (patients 1,2, and 3), on or about December 2003, January 2004, and December 2003, respectively.

4. **Patient 1**

A. In December 2003, Dr. Hsu provided inappropriate or substandard medical care as a physician to Patient 1. Patient 1 was likely a first time patient of Dr. Hsu. She was an 82 year old female who presented to the Hospital emergency room on December 29 with a strong history or coronary artery disease, and a number of other medical problems, including hyperlipidemia and non-insulin-dependent diabetes. She had been at home in her usual state of health when she began to experience right chest pain and right upper discomfort. She admitted to occasional diaphoresis, nausea, and occasional left arm pain and numbness but denied any shortness of breath or pressure sensation. She came in to the hospital right after lunch (12:58) and thought she probably had stomach problems. She said her pain was relieved by belching. She had been experiencing symptoms on and off for three days, her symptoms usually lasting for about 3 to 30 seconds. There was no clear evidence at the hearing about whether her chest pains were consistent or intermittent, though the later is suspected. On the day before admission she tried some of her husband's Nitroglycerin ("Nitro") with some relief (Dr. Hsu did not learn this until the day after admission). Dr. Hsu thought her symptoms were somewhat atypical for heart problems, though he was highly suspicious of heart problems.[1] Exhibit 1, Patient 1, A, at 0001-0004 (Panel B's black binder - hereinafter this portion of Exhibit 1 referring to Patient 1will refer only to the page number - *e.g.*, 0001-0044).

[1] Some of the experts testifying thought that Patient 1 presented with typical symptoms of heart problems, some thought they were atypical.

B. First, Dr. Hsu ordered an EKG (given at 13:30) and blood work (cardiac panel) (13:15). *Id*. at 0009. This first EKG showed significant ST segment elevation. *Id*. at 0036. Her CPK and troponin were negative. *Id.* at 0002. The computer readout or analysis did not diagnose a myocardial infarction.[2] Dr. Hsu was strongly suspicious of a heart attack but did not rule out gastrointestinal problems. An IV was started, she was given aspirin (13:40), and sublingual Nitro (13:40). *Id.* at 0009.

C. Patient 1 was admitted to the Hospital Intensive Care Unit (14:00) with follow-up EKGs and serial enzymes ordered by Dr. Hsu. Dr. Hsu did not order a chest x-ray. *Id.* at 0002 and 0009.

D. After Patient 1 was admitted to the ICU, she was given IV Lopressor (at 14:10), but Thrombolysis was not ordered. *Id.* She was also given IV Heparin, morphine and Nitro paste (prn). Her skin was warm and sweaty. *Id.* at 0011. *See* Physician Orders at *Id.* 0005-0007.

E. Patient 1 seemed to improve; her pain was completely gone. *Id.*

F. At 18:30 Patient 1 took a turn for the worse. She had shortness of breath, was cyanotic, clammy and with audible rales, but had no arrhythmia, and she denied chest pain.

G. A second EKG was given at 18:58 which certainly confirmed an acute anterior myocardial infarction.

H. Thrombolysis (TKN) was administered, along with an ace inhibitor (IV Lasix). Dr. Hsu did not order IV Nitro at this point, either. There were follow-up EKGs done at 19:18, 20:17, and 6:28 (December 30). *Id.* at 0037 - 0040. Patient 1 showed persistent ST elevation but there were later indications of that parts of the heart were getting more blood ("reprofusion beats"). *Id.* 0013.

[2] Nevertheless, several experts testified that the first EKG clearly shows an acute anterior myocardial infarction.

I. Patient 1 settled down in about 15-20 minutes after further treatment was administered that evening. However, Dr. Hsu had decided that Patient 1 needed more aggressive acute care, but thought it risky to move her too soon. In the morning, Patient 1 was awake, free of pain, and eating, and Dr. Hsu talked to her and the family about transfer to a tertiary care center, MedCenter One in Bismarck. He consulted with Dr. Lo at the Heart and Lung Clinic and he agreed to accept her for echocardiogram and follow-up evaluation. *Id*. at 0004.

J. At 11:10 on December 30, Patient 1 was prepared for transfer and was transferred. However, as she was being lifted from her bed to the gurney she coded blue. She was placed in the ambulance and transfer was begun, but she expired on December 30 before reaching MedCenter One.

K. Drs. Lambrecht, Matheson, and Turk all opined at the hearing that Dr. Hsu provided substandard or inappropriate care to Patient 1. Dr. Lambrecht is a specialist in emergency medicine. Dr. Matheson is a family practice specialist. Dr. Turk is a specialist in internal medicine and cardiology.

L. Drs. Hsu and Wilson both opined at the hearing that Dr. Hsu did not provide substandard or inappropriate care to Patient 1. Both are family practice specialists. *See* exhibit H.[3]

M. The appropriateness of care given to Patient 1 centers mostly upon the care provided by Dr. Hsu shortly after admission. Dr. Hsu ordered an EKG and according to most of the testimony the EKG clearly showed an acute anterior wall myocardial infarction, a condition which Dr. Hsu missed. *See* Exhibit H, at 0001. Again, the computer also did not identify an MI. Patient 1 stayed in the Hospital overnight and upon transfer by ambulance to Bismarck coded and

[3] Exhibit H is an opinion from a physician requested to do a "Standard/Quality of Care review for the Hospital." He opined that the care given by Dr. Hsu was appropriate. Exhibit H, at 0003.

expired. According to the most persuasive opinion, the care provided by Dr. Hsu to Patient 1, was substandard or inappropriate because it appears that Dr. Hsu failed to promptly recognize the clear signs of an acute myocardial infarction, though he did promptly recognize the patient was likely a cardiac patient, and because he did not administer thrombolytic therapy immediately after obtaining the first EKG results, and he also failed to use IV-nitro, failed to order a chest x-ray before giving heparin, failed to consult a cardiologist earlier, and failed to transfer her to a tertiary care center early enough. In short, there was chiefly a delay in appropriate care, and some appropriate care was lacking.

N. On the other hand, there was opposite opinion, Dr. Hsu's supported only by Dr. Wilson. *See* the Algorithm for Initial Assessment and Evaluation of the Patient with Acute Chest Pain, guidelines issued by the American College of Cardiology and the American Heart Association, Exhibits K & J ("the guidelines"). These guidelines were in effect during the time periods in question here, but have since been changed to some extent. Testimony of Dr. Lambrecht. They are subject to varying interpretations; however, greater weight is given to the expert testimony of experts testifying for IP-B in regard to Patient 1. *See* FOF no. 4, O below. It appears that although Dr. Hsu can make some argument that his care with regard to Patient 1 was according to the guidelines, *i.e.*, standard and appropriate, it seems clear that his care was too little, too late. In other words, overall, mostly beneath the standard of care and inappropriate. There was also opinion given that Dr. Hsu violated the policy and procedure of the Hospital in his treatment of Patient 1. Exhibit 10. That policy and procedure is not a model of clarity but it appears that that opinion is correct in that Dr. Hsu did not strictly adhere to the Hospital policy and procedure. Especially, he did not order a chest x-ray and did not order immediate transfer upon giving TNK. *Id.*

O. A review of exhibit K & J in light of the expert testimony given both for and against Dr. Hsu, giving greater weight to the experts testifying for Panel B, shows, by the greater weight of the evidence, that Dr. Hsu provided substandard or inappropriate care to Patient 1. Greater weight is given to Panel B's experts because they constituted a mix of family practice, cardiology, and emergency medicine specialists and were more persuasive than the experts for Dr. Hsu, himself and Dr. Wilson, both family practice specialists. Only Dr. Wilson, besides Dr. Hsu, testified at the hearing in regard to Patient 1. Although a Cardiologist gave a peer review opinion to the Hospital, he did not testify at the hearing and could not be cross-examined.[4]

P. Although it is proven that Dr. Hsu provided substandard or inappropriate care to Patient 1, it seems that he was not far from the mark because two other doctors, including another cardiologist claim the standard of care was followed. Genuine arguments have been made on both sides of the issues in regard to Patient 1. Although Panel B has proven its case to the satisfaction of the hearing officer, Dr. Hsu's position seems not grossly off the mark.

5. **Patient 2**

A. Patient 2 was a 96 year old, female patient of Dr. Hsu's whom he had treated since about 1980. She was now in a nursing home. She has dementia, anemia, hypertension, arthritis, uterine cancer and diverticulosus. Her son was acting as power of attorney for her. According to Dr. Hsu, Patient 2 and her son had made it clear to him that she was ready to die, wanted only comfort care, and wanted no other further treatment. Dr. Hsu testified that she was a Code II or III.[5] Yet, Dr. Hsu had been giving her blood transfusions recently for anemia (2 units of blood given on January 6, 2004). Patient 2, A, at 0015 (hereinafter this portion of Exhibit 1 referring to

[4] The ALJ did not give much weight to the standard/quality care review of the other cardiologist because he was not available for cross examination, as was Panel B's cardiologist, Dr. Turk.
[5] There was no record offered in evidence that clearly indicated Patient 2 was assigned a code. Speculation was that such a record would be in her nursing home charts.

Patient 2 will refer either to part A or B of Patient 2 medical records, with appropriate page number). The Complaint in regard to Patient 2 focuses on her treatment by Dr. Hsu for anemia. However, the evidence at the hearing, and the chief allegation of Panel B, focuses on the last sentence of page two of the Complaint, the alleged failure "to properly diagnose and treat the patient who was suffering from hemorrhagic cystiis [*sic*] (bleeding from the bladder secondary to klebsiella infection)." Complaint at 2.

B. On January 19, 2004, at 8:30 a.m., the nursing home called Dr. Hsu at his clinic. They reported that Patient 2 had substantial bleeding from her vagina. At 12:00 noon, Dr. Hsu called back and wanted her hemoglobin checked the next day. At 1:00 p.m., the nursing home called the clinic and reported a "cup of clots in [her] brief," but Dr. Hsu was not at the clinic. At 2:30 p.m., no bleeding was reported. Then, at 2:45 p.m., the nursing home reported to the clinic a "large amount of bleeding." At 3:45 p.m., Dr. Hsu was reached. He called the son and reported to the clinic that the son wanted no treatment; he ordered a "CBC" for the next day. *Id.* at 0021-0022. Dr. Hsu did not issue any other orders for treatment or transfer for Patient 2.

C. There was then a shift change at the clinic. The nursing home called again, at 6:30 p.m., reporting a large amount of blood clots for Patient 2. Dr. Hsu could not be reached so Dr. Matheson, who was on call at the ER in the Hospital, was called. He asked the nursing home to send Patient 2 to the ER for evaluation. He was unable to reach the son and so he called Patient 2's daughter-in-law, who gave permission to transfer Patient 2 to MedCenter One. *Id.* at 0022. Patient 2 was transferred to MedCenter One where she was admitted on January 20, 2004, and eventually diagnosed with hemorrhagic cystitis after considerable examination and workup. Patient 2, B, at 0001-0011; *see also* A, at 0022-0023. Patient 2 was discharged on January 22 and was so happy to be back that she kissed everyone at the nursing home. She reported back with

various bruises apparently obtained during the normal course of examinations, workup, and treatment at MedCenter One.

D. Once Patient 2 was diagnosed, her bladder infection was easily treated with antibiotics.

E. The appropriateness of the care provided by Dr. Hsu to Patient 2 centers on his failure to examine and treat (or transfer) her on January 19, 2004. In essence, he did not know what was causing the substantial vaginal bleeding of Patient 2 on January 19, and, after consulting with the son, Patient 2's POA, he did nothing. Dr. Hsu admitted at the hearing that if he had known that the diagnosis was a bladder infection, he would have ordered treatment. However, his defense is that the family's wishes were honored and because of their wishes no further treatment or examination was ordered, other than a "CBC" for the next day.[6]

F. However, also at issue in this matter is the underlying issue of a lack of documentation regarding Patient 2. Although there was speculation that the nursing home had more and better records on Patient 2, Dr. Matheson had made a search of the medical records for Patient 2 on January 19 and found nothing. Although Dr. Hsu claims that Patient 2 was a Code II or Code III patient, there are no Hospital or clinic records about this.

G. Drs. Lambrecht and Matheson opined about the appropriateness of care provided by Dr. Hsu to Patient 2. They both said it was a violation of the standard of care to not order at least some additional examination and evaluation of Patient 2 as to the cause of her vaginal bleeding, notwithstanding the wishes of the son as expressed to Dr. Hsu by telephone. They both also expressed concern about the lack of documentation, *i.e.*, medical records, for Patient 2,

[6] It is not known exactly what was said by Dr. Hsu to the son when the son declined further treatment for Patient 2 because there is no documentation about it in the medical records other than a note that the son was called and declined further treatment. At the hearing Dr. Hsu said that he explained the situation of Patient 2 to the son as a serious situation but the son wanted no further treatment.

especially with regard to Code status, and more specificity, documentation about the family's wishes for treatment.

H. Drs. Hsu, Muscha, and Wilson all opined about the appropriateness of care provided by Dr. Hsu to Patient 2. They all essentially said that the standard of care was met with regard to Patient 2 because the family's wishes were followed. Although they were each concerned about the fact that Patient 2's situation was potentially very serious and that Dr. Hsu did not know the origin of the vaginal bleed, they all still believed that Dr. Hsu's hands were tied by honoring the wishes of the family.

I. The evidence does not show that Dr. Hsu provided inappropriate or substandard care to Patient 2. This a different case than that of Patient 1, because of the family involvement, and it is much less clear in regard to standard of care issues than was Patient 1's case. Although Dr. Hsu did not know what was causing Patient 2's vaginal bleed, he did accede to the family's wishes as expressed by the son. As it turned out, a different doctor became involved and a different family member gave permission for further treatment when the son could not be reached. As it turned out, Patient A was diagnosed with an easily treatable condition, but only after considerable examination and workup. Dr. Hsu could not have known what examination and workup would be required for Patient A, though he may have had a better idea if he had at least physically examined her, though Dr. Matheson did so and could not diagnose, so he transferred her. It is also not known what, exactly, the son had explained to him or how it was explained by Dr. Hsu. Nevertheless, it would seem, with a patient such as Patient 2, these decisions not to examine and treat must be left to the family, if the family is properly informed. Who could have known, at the outset, when it was apparent that the vaginal bleed was not stopping, whether the result would have been related to previous cervical cancer or something else not so easily

treatable, as opposed to, as it turned out, something so easily treatable. It is true that Patient 2 may have died had not circumstances turned out as they did (Dr. Matheson was able to intervene), but apparently, that was what the family was ready for and wanted.

J. The real failure in this matter, again, is the failure to document. We do not know for certain that the situation was as related by Dr. Hsu. Further, it is difficult for another treating physician to know what Dr. Hsu knows, if he does not document.

6. **Patient 3**

A. Patient 3 is a 91 year old female, long-term resident of a nursing home. Dr. Hsu had been treating her since August 2003. She has a power of attorney for healthcare. She has a history of type II diabetes mellitus, peripheral vascular disease, hypertension, ischemic heart disease, prior CVA, polymyalgia rheumatica, severe osteoarthritis, hiatal hernia, and significant esophagitis. Patient 3, B, at 0009 (hereinafter this portion of Exhibit 1 referring to Patient 3 will refer to part A or B of Patient 3 medical records, with appropriate page number).

B. Patient 3 is a non-ambulatory patient who had a painful corn on her right toe; she had sores on her right foot, both on her bunion and hammertoe. Patient 3, A, at 0001 and 0002. Her sores were infected. Dr. Hsu had ordered a culture and according to the culture was treating her with Keflex, with little success. The infection did not heal and it appeared that amputation of the foot or leg was in order. Dr. Hsu came to the conclusion, however, that if he could reduce the rubbing of her corn by her footwear and relieve the pain, the infection may heal, but he believed this would require a flexor tendon release so that the tension on the skin could be relaxed and the corn could be debrided. His purpose was to correctly align the toe so there would not be excess pressure over the PIP joint, relieving the rubbing that helps create the corn. Dr. Hsu said that he knew this was a simple procedure, ordinarily, but fraught with problems in this case. Dr. Hsu

consulted with Dr. Pierce, an orthopedic surgeon, in Bismarck, discussing the procedure, his purpose, and the risks. He also discussed the procedure with Patient 3's health care POA, advising that this was a more conservative treatment, in opposition to amputation, but also advising of the risks, and further advising that he did not have privileges to do the procedure in the Hospital and that he would have to do the procedure in his office. A, at 0002.[7]

C. Dr. Hsu did not have privileges to do a flexor tendon release at the Hospital so he did it in his office. Dr. Hsu's consultation with Dr. Pierce lasted from two to five minutes. Dr. Pierce testimony. Dr. Hsu had done flexor tendon repairs in the past but never a flexor tendon release.

D. When Dr Hsu performed the procedure he debrided the ulcerated tissue and dissected the flexor tendon on the second toe of the right foot. He opened the corn and found a very serious infection. He removed gangerous tissue. Dr. Hsu testified that if knew the infection was so advanced he would not have done the flexor tendon release but would have proceeded to amputation. However, he was already committed to the procedure and followed through with it.

E. Dr. Hsu did not take a deep wound culture of the toe during the procedure that day. He later took a culture. He restarted Keflex. He did not order a vascular consult or work-up before the procedure. He did not order an x-ray.

F. Patient 3's gangrene did not heal even with a later change in antibiotics and she eventually had to have her left leg amputated below the knee. *Id.* at B.

F. Dr. Lambrecht, Dahl, Koester, and Matheson opined for Panel B about Dr. Hsu's care for Patient 3. They expressed concerns that Dr. Hsu did not use of the proper antibiotic; that additional cultures should have been done, especially a deep would culture during the procedure,

[7] There is no medical record of any consult with Dr. Pierce and there is no written consent in the medical records from the POA. Dr. Pierce testified at the hearing that he had a consult with Dr. Hsu in regard to Patient 3.

that a vascular consult was not done, and that the documentation associated with Dr. Hsu doing this procedure was very poor. They said it was necessary to obtain a vascular consult before the procedure to evaluate the reason for the pain and sores (infection). They said there should have been more written documentation associated with this procedure, especially a consent from POA, under these circumstances. They said the procedure, although it commonly could be performed in an office, should not have been performed in Dr. Hsu's office, under the circumstances. They did not say that the performance of the procedure itself was in any way lacking. However, they all agreed that, overall, Dr. Hsu's performance in regard to the care he gave Patient 3 was below the standard of care. Dr. Dahl opined that the procedure Dr. Hsu did was not necessary for a hammer toe (he has never done a flexor tendon release for a hammer toe), but he said a tendon release may have been necessary for Dr. Hsu to do to do what he intended to do in this case, *i.e.*, eliminate the rubbing or pressure and to try and alleviate the pain. He said from looking at the records, however, he is not sure what Dr. Hsu was trying to do. Dr. Dahl said he would have gone straight to an amputation of the foot or leg.

G. Drs. Pierce, Hsu, Wilson, and Muscha opined about Patient 3 on Dr. Hsu's behalf. They opined that Dr. Hsu's performance in regard to the care given to Patient 3 was not below the standard of care. They said a vascular consult was not necessary, considering the situation with this patient, that the procedure could be performed in an office, though that was not the best place under the circumstances, and that a deep culture or the wound during the procedure, although desirable, was not necessary. However, Dr. Pierce, upon cross examination, was not certain that he would have done the procedure on this patient. He also said that he would have gotten a deep wound culture during the procedure and probably would have taken an x-ray.

H. The evidence does not show that Dr. Hsu provided inappropriate or substandard care to Patient 3, except, again, the evidence does show a failure with regard to obtaining and providing appropriate documentation. With regard to Patient 3, the hearing officer believes the experts testifying on behalf of Dr. Hsu are more persuasive. Also, as with Patient 2, the family's wishes for Patient 3 are a large factor. This is a close call; however, rather borderline.

7. The Code of Medical Ethics of the American Medical Association comments on the patient physician relationship. *See, e.g.,* American Medical Association Code of Medical Ethics, E-10.01 Fundamental Elements of the Patient-Physician Relationship; E-10.015 The Patient-Physician Relationship. It is clear from these sections that the patient has the right to make decisions regarding the health care that is being recommended by the patient's physician, and that a patient may accept or refuse medical treatment. Although it is also clear in these sections that the care of the patient is a collaborative effort between physician and patient, a physician may only provide treatment without consent in rare instances, *e.g.*, pursuant to court order.

8. Virtually all of the medical experts testifying in this matter (at least those that were asked the question), agreed that the patient's decision holds great weight. As one family practice physician put it, it is the relationship of the doctor with the patient and the patient's wishes that primarily govern the course of care provided by a doctor to the doctor's patient. "The patient has the right to determine the care to be provided and the doctor can not take that [right] away."[8] Clearly, the evidence shows that Dr. Hsu had a prior physician patient relationship with both Patient 2 and 3, and he solicited their wishes (from their legal representative, both of them being demented) prior to providing care. However, it is not really clear exactly what was said in obtaining their wishes and their wishes are only known because Dr. Hsu briefly noted the

[8] Testimony of Dr. Muscha.

conversations rather than obtaining written consent. With regard to Patient 2, although Dr. Hsu knew the patient's wishes that no further treatment be provided, he did not know what was causing her vaginal bleeding. It is not clear from the medical record that the son did not at least want to find out what was causing the vaginal bleeding, though Dr. Hsu's testimony would lead us to believe that he did not. Proper documentation in regard to consent and patient wishes is crucial. In regard to Patient 3, although Dr. Hsu obtained permission to proceed with the flexor tendon release in order to hopefully relieve Patient 3's pain, he did not have full knowledge of the situation. It is not clear from the medical record that the POA had full knowledge. Would the POA have wanted to find out more about Patient 3's situation and wanted to proceed with the risky conservative care Dr. Hsu was proposing if they had full knowledge? That is not known; proper documentation was lacking. Nevertheless, a convincing argument has been made that at least with regard to Patient 2 and 3, Dr. Hsu was operating within the realm of an established physician/patient relationship and according to the patient's wishes and not below the standard of care, though he otherwise would have been operating below the standard of care. However, again Dr. Hsu's recordkeeping of the relationships and the transactions in providing patient care given is very poor. With regard to Patient 1, there was no prior physician/patient relationship. Dr. Hsu was operating on his own in his decision making, for the most part. With Patient 1 his care was below the standard of care, but not grossly so.

ANALYSIS

As stated previously, in the First Decision, Dr. Hsu does not seem to recognize that he is not an island. He tends to gauge whether he gives proper medical care by the likely costs and by the actual results rather than proper protocols. He tends to believe that a low cost and the end result justifies the procedures used. To a large extent, it appears, Dr. Hsu has been lucky. With

Patient 1, however, he was not so lucky. As stated previously, the evidence from the last hearing clearly showed that Dr. Hsu is a not a great physician, but neither does that evidence, even when coupled with the evidence from this hearing, show that he is a poor physician. Rather, the evidence shows that he is a caring physician, though perhaps a somewhat misguided physician.

Dr. Hsu acknowledged at the first hearing that he is "out of step" with what the practice of medicine currently requires for appropriate care of patients in North Dakota. He maintains that he operates on a basis of mutual trust between patient and physician, and that no one has been harmed by the care he has given to patients over the years. Again, that may not be the case, now, considering the evidence at this hearing. It is clear that in the rural health care setting Dr. Hsu is doing what he believes is best to keep down the costs of medical care for his patients, while still giving them adequate care. With this purpose, "no harm no foul" seems to be Dr. Hsu's response and his motto in regard to the allegations of inappropriate care. Whether he will continue in his purpose employing his motto remains to be seen.

Although the ALJ did not read the many letters provided by the citizens of Elgin, he is aware of them and he noted the presence of many at the hearing. It seems that Dr. Hsu has the support of many in the community, or, at least, they support having a doctor in the community.

Finally, it is ultimately difficult to determine if there has been inappropriate medical care given in several of these cases (from both hearings) when there is not proper documentation, *i.e.*, not timely documentation of appropriate substance. This is especially so when it comes to physician/patient relationships and informed consent. There remain many questions not really answered by the medical records but only by Dr. Hsu's testimony and speculation. This, by itself is not right, or appropriate medical care. In regard to documentation only, or lack thereof, his patients may suffer. Has he really performed to date as he has indicated? Perhaps, for the

most part, Dr. Hsu has provided adequate medical care, the care required under the circumstances, or at least the care his patients want. But, according to the testimony of many doctors and some doctors who know rural medicine, Dr. Hsu has not been providing appropriate documentation in several instances, and likely, not for many other cases not part of these two Complaints.

Again, Dr. Hsu believes that his after-the-fact explanations of what occurred, and why, is appropriate. Yet, even if he is right as to the substance of the care he has given his patients, as being appropriate, he presents a disservice to his patients and to others in the medical profession by not providing timely and adequate documentation. As shown at the first hearing and confirmed at this hearing, about his documentation there is no doubt, it is inadequate and sometimes nonexistent.

CONCLUSIONS OF LAW

1. Dr. Hsu is currently licensed to practice medicine in North Dakota under the provisions of N.D.C.C. ch. 43-17. Therefore, he is subject to the provisions of ch. 43-17 that regulate the practice of medicine in North Dakota.

2. Under N.D.C.C. § 43-17-30.1, the Board may take a variety of disciplinary actions against licensed physicians in North Dakota for violation of any of the provisions of N.D.C.C. § 43-17-31, including revocation of license.

3. N.D.C.C. § 43-17-31, states, in part, as follows:

> 43-17-31. Grounds for disciplinary action. Disciplinary action may be imposed against a physician upon any of the following grounds:
>
> ***
>
> 21. A continued pattern of inappropriate care as a physician…

***

4. Within the meaning of N.D.C.C. § 43-17-31(21), inappropriate care means not only the actual medical care provided by the physician but all aspects associated with that care including adequate and timely documentation of the care provided by the physician. Appropriate care means the standard of care currently required for patients by the North Dakota medical community. Inappropriate care is substandard care.

5. Under N.D.C.C. § 43-17-31.1, the costs of the prosecution of the disciplinary proceeding may be assessed against a physician against whom disciplinary action is imposed.

6. Under N.D.C.C. § 43-17-32.1, the Board may temporarily suspend a license to practice medicine in North Dakota to prevent continued practice that would create a significant risk of serious and ongoing harm to the public while a disciplinary proceeding is pending. A temporary order of suspension remains in effect until a final order is issued by the Board after a full hearing or appeal, on until the suspension is terminated by the Board. However, a hearing must be held within thirty days after the issuance of a temporary suspension. The hearing in this matter was not held within thirty days, but that provision is considered waived because Dr. Hsu first requested the rescheduling of the hearing pursuant to the temporary suspension, until June, and then again requested rescheduling, until August. Accordingly, the temporary suspension remains in effect until after the Board's final decision after the full hearing.

RECOMMENDED ORDER

The greater weight of the evidence has already shown that Dr. Hsu violated the provisions of N.D.C.C. § 43-17-31(21) in that he has engaged in a continued pattern of inappropriate care as a physician in North Dakota with regard to the care he has given to the seven patients that were the subject of the first Complaint. *See* First Decision. In regard to the

current matter, the second Complaint, the greater weight of the evidence shows a continued pattern of inappropriate care as a physician in North Dakota with regard to the care he has given to Patient 1.

At the second hearing, Panel B recommended a revocation with no conditions. The pattern of inappropriate care with regard to the seven patients of the first Complaint is seen by Panel B as a separate pattern that has now been followed, after notice to Dr. Hsu that the Board is investigating him and is taking action, by a second pattern of inappropriate care, the allegations of the second Complaint. The ALJ does not share this view.

The first pattern of inappropriate care extended from July 2001 until June 2003. A hearing was held and the ALJ issued his recommended decision on November 23, 2003. The Board subsequently adopted the ALJ's recommended findings and conclusions but took no action imposing administrative disciplinary action, or penalty, because of the pending action on the second Complaint. Thus, Dr. Hsu has not really been put on notice as to the actual result, *i.e.*, administrative disciplinary action contemplated by the Board for the proven violations at the first hearing. Panel B says that Dr. Hsu was put on notice that the Board found him in violation of N.D.C.C. § 43-17-31(21), a continued pattern of inappropriate care as a physician, before the end of the year and he knew that the Panel B was investigating him in regard to patients in the second Complaint, so that he was put on notice that he needed to reform in regard to the care he provided to patients. In fact, Panel B says that Dr. Hsu was put on notice in regard to the care he provided to patients just by the mere fact that Panel B was investigating the care he provided that resulted in the first Complaint.

The allegations of the second Complaint do not arise until Dr. Hsu provided care to Patient 1 in late December 2003, to Patient 2 in early January 2004, and to Patient 3 in

December 2003. The problem with saying Dr. Hsu was put on notice that he needed to reform (and did not), thus the allegations of the second Complaint should be considered separate, is the short passage of time. True, Dr. Hsu was put on notice as to the Board's concern, but he was not put on notice as to the extent of the Board's concern until later November 2003, and not as to results of the Board's concern at all. The Board has not issued a final order.

The ALJ is not privy to the exact date the Board adopted his findings and conclusions from the first hearing, nor the date that was communicated to Dr. Hsu, but there could not have been much time, if any, between the communication to him of the Board's action and the beginning of the care he was providing to the patients in the second Complaint. Moreover, again, there was no notice about discipline, no finality to the administrative action, because the Board had not yet decided on discipline.

The ALJ sees the care provided to Patients 1-3 in this matter as part of the same pattern of care and believes that the discipline warranted for violations found as a result of the second Complaint should not, necessarily, be added on to the discipline warranted as a result of the first Complaint. Because he finds only one additional violation in a continued pattern of inappropriate care as a result of the second Complaint and because even that violation is not a gross violation, the ALJ now sees a continued pattern of care with regard to eight proven violations. He sees Dr. Hsu in the same position as before in regard to discipline.

Accordingly, the ALJ still recommends that the license to practice medicine in North Dakota of Dr. Hsu be revoked, unless Dr. Hsu agrees to the practice of medicine in North Dakota under a system of monitoring and review as required by the Board in its discretion. If Dr. Hsu agrees to a system of monitoring and review of his practice of medicine in North Dakota as required by the Board, the ALJ recommends that the Board issue a letter of censure to Dr. Hsu

for the violations proven as a result of the hearings on the two Complaints, and that the letter of censure include a statement of the Board's specific requirements of a system of monitoring and review of Dr. Hsu's practice of medicine in North Dakota.

The system of monitoring and review of Dr. Hsu's practice of medicine in North Dakota shall be in place for a reasonable length of time as determined by the Board to assure future compliance with the law by Dr. Hsu without monitoring and review. At the end of the period of monitoring and review, Dr. Hsu shall be reinstated to full standing as a physician to practice medicine in North Dakota under the provisions of N.D.C.C. Ch. 43-17.

If Dr. Hsu agrees to the imposition of a system of monitoring and review by the Board but later fails to comply with any of the terms and conditions of the system of monitoring and review as specifically required by the Board, the Board may unilaterally take administrative action to revoke Dr. Hsu' s license to practice medicine in North Dakota, or take such other administrative action as authorized by N.D.C.C. § 43-17-30.1, subject only to the right of Dr. Hsu to request a hearing to determine whether the Board's further unilateral administrative action was appropriate, *i.e.*, whether, indeed, Dr. Hsu failed to comply with any of specific terms and conditions of the system of monitoring and review required by the Board.

Because of the violations of N.D.C.C. § 43-17-31 proven at the hearing in regard to the First Decision and in this Second Decision, Dr. Hsu shall pay to the Board a sum not to exceed the reasonable and actual costs, including reasonable attorney's fees, incurred by the Board and its investigative panel B in the investigation and prosecution of both the first Complaint and the second Complaint. The Board shall state the sum Dr. Hsu is to pay along with the means and method of payment in a separate letter that will be attached to the Board's final Order in this matter.

Finally, it should be noted that already Dr. Hsu has suffered some penalty for his actions in regard to these two complaints. He has had his license temporarily suspended for a rather long period of time, since March 19, 2004. This has been a considerable penalty for him and the community of Elgin.

Dated at Bismarck, North Dakota, this 27th day of September, 2004.

State of North Dakota
Board of Medical Examiners

By: _____
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